



AUTHORIZATION TO RELEASE PATIENT INFORMATION

Patient Name: _____ Patient Phone No.: _____ Date of Birth: _____

- 1. I authorize the use or disclosure of the above named individual's health information as described below:
- 2. The following individual or organization is authorized to make the disclosure: **Doctor's Hospital of Michigan**

Address: _____

- 3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

<input type="checkbox"/> Problem list	<input type="checkbox"/> Most recent history and physical
<input type="checkbox"/> Medication list	<input type="checkbox"/> Laboratory results from (date) _____ to (date) _____
<input type="checkbox"/> List of allergies	<input type="checkbox"/> X-ray and imaging reports from (date) _____ to (date) _____
<input type="checkbox"/> Immunization record	<input type="checkbox"/> X-ray films from (date) _____ to (date) _____
<input type="checkbox"/> Most recent discharge summary	
<input type="checkbox"/> Consultation reports	from (doctors' names) _____
<input type="checkbox"/> Entire record	from (date) _____ to (date) _____
<input type="checkbox"/> Other _____	

- 4. I understand that the information in my health record may include information relating to: sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), behavioral or mental health services, treatment for alcohol and drug abuse, and genetic testing; and I consent to the release of that information.

- 5. This information may be disclosed to and used by the following individual or organization:

Address: _____
for the purpose of: _____

- 6. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to Doctors' Hospital of Michigan Medical Records Department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

- 7. I understand that authorizing the disclosure of this health information to the individual or organization named above is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524 and consistent Doctors' Hospital of Michigan's Policies and Procedures. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal or state confidentiality rules. If I have questions about disclosure of my health information, I can contact the Patient Relations Representative at 248-857-7200.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Patient or Personal Representative Signature Dated: _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient: _____ Print Name: _____

Source of Authority (attach relevant documents as applicable) _____